

OUTPATIENT TREATMENT REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

Date _____

MEMBER INFORMATION

Name _____

DOB _____

Member ID # _____

PROVIDER INFORMATION

Provider Name (print) _____

Provider/Agency Tax ID # _____

Provider/Agency NPI Sub Provider # _____

Phone _____ Fax _____

CURRENT ICD DIAGNOSIS

Primary _____

Secondary _____

Tertiary _____

Additional _____

Additional _____

Has contact occurred with PCP? Yes No

Date first seen by provider/agency _____

Date last seen by provider/agency _____

FUNCTIONAL OUTCOMES (TO BE COMPLETED BY PROVIDER DURING A FACE-TO-FACE INTERVIEW WITH MEMBER OR GUARDIAN. QUESTIONS ARE IN REFERENCE TO THE PATIENT).

- In the last 30 days, have you/your child had problems with sleeping or feeling sad? Yes (5) No (0)
 - In the last 30 days, have you/your child had problems with fears and anxiety? Yes (5) No (0)
 - Do you/your child currently take mental health medicines as prescribed by your doctor? Yes (0) No (5)
 - In the last 30 days, has alcohol or drug use caused problems for you or your child? Yes (5) No (0)
 - In the last 30 days, have you/your child gotten in trouble with the law? Yes (5) No (0)
 - In the last 30 days, have you/your child actively participated in enjoyable activities with family or friends (e.g. recreation, hobbies, leisure)?
 Yes (0) No (5)
 - In the last 30 days, have you/your child had trouble getting along with other people including family and people out the home?
 Yes (5) No (0)
 - Do you/your child feel optimistic about the future? Yes (0) No (5)
- Children Only**
- In the last 30 days, has your child had trouble following the rules at home or school? Yes (5) No (0)
 - In the last 30 days, has your child been placed in state custody (DCF criminal justice)? Yes (5) No (0)

INDICATE PREVIOUSLY RECEIVED SERVICES:

Individual Therapy Family Therapy Group Therapy Community Support Services (H0036) Targeted Case Management

Please indicate if the patient has been diagnosed with Autistic Spectrum Disorder and/or has had inpatient hospitalizations?

Autistic Spectrum Disorder Inpatient Hospitalizations MYPAC

Please list all current medications: If prescribed medication, is member compliant? Yes No

Therapeutic Approach/Evidence Based Treatment Used

LEVEL OF IMPROVEMENT TO DATE

Minor Moderate Major No progress to date Maintenance treatment of chronic condition

Barriers to Discharge

CURRENT SYMPTOMS (IF PRESENT, CHECK DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
Anxiety/Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity/Inattention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability/Mood Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Psychotic Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angry Outbursts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (include severity): _____				

PLEASE INDICATE HISTORICAL SYMPTOMOLOGY DATA

FUNCTIONAL IMPAIRMENT RELATED SYMPTOMS (IF PRESENT, CHECK DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
ADLs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work/School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug(s) of Choice: _____				
Last Date of substance use: _____									

RISK ASSESSMENT

Suicidal:	<input type="checkbox"/> None	<input type="checkbox"/> Ideation	<input type="checkbox"/> Planned	<input type="checkbox"/> Imminent Intent	<input type="checkbox"/> History of self-harming behavior
Homicidal:	<input type="checkbox"/> None	<input type="checkbox"/> Ideation	<input type="checkbox"/> Planned	<input type="checkbox"/> Imminent Intent	<input type="checkbox"/> History of self-harming behavior
Safety Plan in place? (If plan or intent indicated):	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

CURRENT MEASUREABLE TREATMENT GOALS

REQUESTED AUTHORIZATION (PLEASE CHECK OFF APPROPRIATE BOX TO INDICATE MODIFIER, IF APPLICABLE.)

Behavioral Health Outpatient Services (billed as CPT codes)	FREQUENCY: How Often Seen	INTENSITY: # Units Per Visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
<input type="checkbox"/> Individual Therapy				
<input type="checkbox"/> Family Therapy				
<input type="checkbox"/> Group Therapy				
Case Management (T1017)				
<input type="checkbox"/> Adult (15 minute units)				
<input type="checkbox"/> Child (15 minute units)				
Psychosocial Rehabilitation (H2030)				
<input type="checkbox"/> Adult (15 minute units)				
<input type="checkbox"/> Senior (15 minute units)				
<input type="checkbox"/> Community Support Services (H0036) (15 minute units)				
<input type="checkbox"/> Assertive Community Treatment (H0039) (15 minute units)				
<input type="checkbox"/> Day Treatment (child) (H2012) (per hour)				
<input type="checkbox"/> Wraparound Facilitation (H2021) (15 minute units)				
<input type="checkbox"/> MYPAC (H2022 HT) (1 day)				
If you are a nonparticipating provider only, please indicate here any additional codes you are requesting an authorization for. Other code(s) requested:				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

PROVIDER NAME _____

DATE _____

PROVIDER SIGNATURE _____

SUBMIT TO
Utilization Management Department
 Phone: 1.866.912.6285 Fax: 1.866.694.3649